Senate Budget and Fiscal Review—Nancy Skinner, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Susan Talamantes Eggman, Ph.D., Chair
Senator Melissa Melendez
Senator Richard Pan, M.D.

Tuesday, May 11, 2021
1:30 p.m.
State Capitol - Room 3191

Consultant: Scott Ogus

PART B

PUBLIC COMMENT

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling (916) 651-1505. Requests should be made one week in advance whenever possible.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Program Integrity Data Analytics

Budget Change Proposal – April Finance Letter. DHCS requests expenditure authority of $6.9 million ($1.1 million General Fund and $5.8 million federal funds) in 2021-22 to extend contract funding for the Medi-Cal Program Integrity Data Analytics service.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$1,130,000	$-
0890 – Federal Trust Fund	$5,755,000	$-
Total Funding Request:	**$6,885,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The DHCS Audits and Investigations (A&I) division is responsible for financial auditing and detection of fraud and abuse among providers of health care services to Medi-Cal beneficiaries. The mission of A&I's Medi-Cal Fraud Investigations Branch is to protect the fiscal integrity of California's publicly funded health care programs. Investigations Branch fraud investigators are sworn law enforcement officers and conduct criminal, administrative and civil investigations into various types of suspected Medi-Cal program fraud. This fraud may involve beneficiaries or providers of programs under the purview of DHCS, as well as the In-Home Supportive Services (IHSS) program administered by the Department of Social Services (DSS).

In 2010, the United States Congress required the federal Centers for Medicare and Medicaid Services (CMS) to implement a predictive analytic modeling system to detect fraud in the Medicare program. Based upon the successful implementation of this system for Medicare, CMS began encouraging state Medicaid programs to pursue new data analytics technologies, as well. In addition, the federal Patient Protection and Affordable Care Act (ACA) required Medicaid programs to implement new program integrity requirements to prevent, detect, and take enforcement action against fraud. According to DHCS, the traditional model of recoveries for overpayment or fraud and abuse is "pay and chase", in which efforts must be made to recoup overpayments identified after the payments have already been made. Data analytics are a strategy intended to provide front-end fraud prevention and program integrity.

In 2013, after news reports identified significant numbers of fraudulent providers in the Drug Medi-Cal system, A&I engaged in a comprehensive review of all Drug Medi-Cal providers. The Investigations Branch visited 497 facilities, suspended 87 providers, and sent 98 fraud referrals to the California Department of Justice resulting in criminal charges against 48 providers and 137 affiliated individuals. During its review of the Drug Medi-Cal program, DHCS complemented its field work with a short-term limited scope contract for enhanced data analytics services. According to DHCS, the data analytics tool identified many of the same suspect providers in a fraction of the time spent identifying fraudulent providers via labor intensive field visits.

The 2014 Budget Act authorized limited-term expenditure authority of $5 million ($1.3 million General Fund and $3.8 million federal funds) in 2014-15, $10 million ($2.5 million General Fund and $7.5 million

federal funds) in 2015-16 and 2016-17, and $5 million ($1.3 million General Fund and $3.8 million federal funds) in 2017-18 to secure a data analytics contractor to expand on the success of these activities experienced during the review of Drug Medi-Cal providers. However, due to procurement challenges, only a portion of the appropriated funds were used for a narrow pilot focused on Drug Medi-Cal and specialty mental health services claims. The investigative use of these tools occurs in a multi-disciplinary Special Investigations Unit within the Investigations Branch at A&I.

The 2018 Budget Act included expenditure authority of $9 million ($2.3 million General Fund and $6.8 million federal funds) in 2018-19 and up to $10 million ($2.5 million General Fund and $7.5 million federal funds) in 2019-20 to extend the data analytics contract for an additional two years.

Resource Request. DHCS requests expenditure authority of $6.9 million ($1.1 million General Fund and $5.8 million federal funds) in 2021-22 to extend contract funding for the Medi-Cal Program Integrity Data Analytics (MPIDA) service. According to DHCS, the MPIDA service provides the department with access to tools and data that increase the probability of identifying fraud, including a cloud-based interactive dashboard with geo-mapping capabilities, the ability to sort provider and beneficiary information based on fraud indicators, and data analytics tools to identify patterns of suspicious behavior based on historical data and changing behaviors. The MPIDA service also provides access to several proprietary databases to perform link analysis, which can identify a provider's known business associates to determine if there are warning signs of fraud, if other providers are engaged in similar fraudulent behavior, or if the fraudulent behavior is part of an organized scheme.

DHCS indicates the MPIDA service would be used to focus on pharmacy claims, as the Medi-Cal program transitions pharmacy benefits from the managed care to fee-for-service delivery system under Medi-Cal Rx. In concert with the Medi-Cal Rx vendor, DHCS indicates it would use the MPIDA tools to identify:

- High-risk prescribers
- Geospatial anomalies between beneficiary, prescriber, and pharmacy locations
- Maximum daily equivalent anomalies by prescriber, pharmacy, or beneficiary
- Overprescribing of high-risk drugs such as antipsychotics and opioids
- Counter indicated prescribing such as concurrent prescriptions of opioids and benzodiazepines or antipsychotics
- Billing for the maximum amount of refills
- Avoiding use of generics where appropriate
- Billing for brand name drugs while providing generics
- Short filling of prescriptions
- Receiving or reselling discounts without passing them along to Medi-Cal
- Prescriptions without an indicated Medi-Cal corresponding provider visit.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 2: Interoperability Federal Final Rule Compliance

Budget Change Proposal – April Finance Letter. DHCS requests expenditure authority of $2.9 million ($713,000 General Fund and $2.1 million federal funds) in 2021-22 and $737,000 ($184,000 General Fund and $553,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to support compliance with federal interoperability and patient health information access rules.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$713,000	$184,000
0890 – Federal Trust Fund	$2,141,000	$553,000
Total Funding Request:	**$2,854,000**	**$737,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2022-23.

Background. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorized approximately $4.5 billion for California for both the Medicare and Medi-Cal electronic health records (EHR) incentive programs. Of the $4.5 billion for California, it is estimated that approximately $2 billion in incentive payments will be made to qualified Medi-Cal health care providers who adopt, implement, or upgrade and meaningfully use electronic health records in accordance with federal requirements. In addition to the efforts to encourage use of EHRs, the federal Centers for Medicare and Medicaid Services (CMS) has sought to promote and improve interoperability, allowing the exchange of health information between different systems. The Medi-Cal EHR program, now called the Medi-Cal Promoting Interoperability Program (PIP), has administered the ARRA HITECH program since 2009.

Although the ARRA HITECH programs and funding are scheduled to end in fall 2021, CMS continues to advance interoperability requirements, as well as patient access to health information. In May 2020, CMS finalized the Interoperability and Patient Access Final Rule (CMS-9115-F), which included the following new requirements for CMS-regulated health care payers, including Medi-Cal fee-for-service and managed care delivery systems:

- Patient Access Application Programming Interface – Payers are required to implement and maintain a secure application programming interface (API) that allows patients to easily access their claims and encounter information, including cost, as well as a defined subset of their clinical information through third-party applications of their choice.
- Provider Director API – Payers are required to make provider directory information publicly available via a standards-based API.
- Payer-to-Payer Data Exchange – Payers are required to exchange certain patient clinical data at the patient's request, allowing the patient to take their information with them as they transition between payers.
- Federal-State Data Exchanges for Dual-Eligibles – States are currently required to exchange enrollee data for individuals dually eligible for Medicare and Medicaid. The new rule requires data to be exchanged daily, rather than monthly.

- Public Reporting and Information Blocking – Defines and creates possible penalties and disincentives for information blocking by certain providers. CMS will report on providers that may be information blocking based on attestations in the Promoting Interoperability Program requirements. Public reporting of this information would allow patients to choose providers more likely to support electronic access to their health information.
- Digital Contact Information – Collects and reports data on providers who do not list or update digital contact information.

The 2015 Budget Act included five positions, funded by a 10 percent allocation from the Health Care Services Plan Fines and Penalties Fund and 90 percent from federal funds, to support ARRA HITECH implementation. As the ARRA HITECH funding is expiring, DHCS is seeking to extend these five positions to support the new interoperability requirements from the new federal rule.

Resource Request. DHCS requests expenditure authority of $2.9 million ($713,000 General Fund and $2.1 million federal funds) in 2021-22 and $737,000 ($184,000 General Fund and $553,000 federal funds) annually thereafter to support compliance with federal interoperability and patient health information access rules. In particular, DHCS reports the implementation of the patient access and provider directory APIs, as well as the public reporting and information blocking, are the most near-term priorities for the department and CMS. The federal rule requires the patient access and provider directory APIs to be implemented by January 1, 2021, and the public reporting and information blocking components targeted to early 2021. According to DHCS, the department will not meet these deadlines due to its focus on COVID-19 response efforts, but CMS has indicated it will work with states as long as they present clear approaches and adequate timelines for implementation. In addition, the digital contact information is required by early 2021 and the payer-to-payer data exchange by January 1, 2022. The specific positions and contract resources requested are as follows:

Health Information Management Division

- **One Staff Services Manager I** would lead a team of staff to plan and coordinate the business elements of the interoperability implementation, health information exchange, and clinical data exchange initiatives and programs.
- **One Staff Services Manager I Specialist** would act as lead business analyst, providing subject matter expertise regarding interoperability, health information exchange, and clinical data exchange to Medi-Cal programs, Medi-Cal managed care plans, and others.
- **One Research Scientist III** position would develop metrics, specifications, and data files based on incoming clinical data collected and stored in department data resources.
- **One Associate Governmental Program Analyst** (**AGPA)** would function as a business analyst, writing required state and federal documents, leading tests to confirm system readiness for data exchange, performing assessments to confirm data is exchanged in a secure and sustainable manner, reviewing system requirements documents align with regulatory requirements and internal policies, and acting as liaison for various entities involved in health information exchange.
- **One AGPA** would act as a project support technician, reviewing program and plan readiness and performance, processing invoices, creating and submitting performance reports, assisting in the development of an interoperability and clinical data exchange roadmap, and acting as an interoperability and clinical data exchange liaison for internal entities.

Contracting Resources

- **Lead Interoperability Business Analyst Contract** – DHCS requests expenditure authority of $250,000 ($63,000 General Fund and $187,000 federal funds) in 2021-22. This contract would provide leadership and specialized subject-matter expertise for all business analysis, policy, process, and change activities related to interoperability compliance.
- **Interoperability Compliance Business Analysis Team** – DHCS requests expenditure authority of $400,000 ($100,000 General Fund and $300,000 federal funds) in 2021-22. This contract would provide two staff to perform business analysis functions with specialized knowledge of and experience with federal interoperability compliance. This team would conduct gap analysis, requirements gathering, market research, and business rules elicitation.
- **Interoperability Compliance Change Management and Business Process Design Team** – DHCS requests expenditure authority of $400,000 ($100,000 General Fund and $300,000 federal funds) in 2021-22. This contract would provide two staff to perform change management and business process evaluation functions, including verifying both systems and staff are prepared to achieve the required outcomes as effectively and efficiently as possible.
- **Lead Interoperability Technical Team** – DHCS requests $1.3 million ($313,000 General Fund and $937,000 federal funds) in 2021-22. This contract would provide five staff to support technical leadership and specialized subject matter expertise for the overall technical planning effort, including potential prototyping and concept development.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: Managed Care Plan Statewide Procurement

Budget Change Proposal – April Finance Letter. DHCS requests 11 positions and expenditure authority of $2.7 million ($1.3 million General Fund and $1.3 million federal funds) in 2021-22, $2.5 million ($1.3 million General Fund and $1.3 million federal funds) in 2022-23 through 2024-25, and $1.6 million ($777,000 General Fund and $777,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to support the statewide Medi-Cal managed care program re-procurement effort.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$1,336,000	$1,255,000
0890 – Federal Trust Fund	$1,336,000	$1,255,000
Total Funding Request:	**$2,672,000**	**$2,510,000**
Total Requested Positions:	**11.0**	**11.0**

* Additional fiscal year resources requested: 2023-24 through 2024-25: $2,510,000, 2025-26 and ongoing: $1,554,000.

Background. The managed care model of health care service delivery in California began in the 1970s with legislation that culminated in passage of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). In addition to regulatory oversight of the commercial managed care market, the Knox-Keene Act authorized the state to license health maintenance organizations and pre-paid health plans to enroll Medi-Cal beneficiaries. Beginning in 1981, the state began licensing different models of managed care delivery for Medi-Cal beneficiaries in different counties. Today, there are four primary models of managed care delivery in the Medi-Cal program:

- *County Organized Health Systems* – In 1982, the Legislature authorized the creation of three county organized health systems (COHS), which are county-administered managed care plans. Santa Barbara and San Mateo Counties were the first COHS plans to enroll beneficiaries (a COHS was planned in Monterey, but was never implemented), while Congress approved three additional COHS (Santa Cruz, Solano, and Orange) counties in 1990. The authorization for COHS requires that they be an independent, public entity and that they meet the regulatory requirements of the state's Knox-Keene Act. However, they need not obtain a license under the Knox-Keene Act, as they are specifically exempted. There are currently twenty-two counties in the COHS model: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo. Eight of these counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) were part of the expansion of Medi-Cal to rural counties described below (see *Expansion to Rural Counties*, below). Beneficiaries in these counties receive services through Partnership Health Plan of California.

- *Geographic Managed Care* – In 1992, the department designated Sacramento County as a geographic managed care (GMC) county, which allowed many plans to operate within the county to provide services to Medi-Cal beneficiaries. In 1998, San Diego also became a GMC county, and both counties currently contract with several commercial health plans with the goal of providing more choice to beneficiaries. As these plans are commercial plans, they are required to

be licensed under the Knox-Keene Act. Sacramento and San Diego remain the only two GMC counties in the state.

- *Two Plan Model* – In 1995, as part of a significant expansion of Medi-Cal managed care, twelve counties were designated to participate in a new Two Plan Model for managed care delivery. Under this model, one county-developed plan, a local initiative, offers services alongside a commercial plan. Both plans are required to be licensed under the Knox-Keene Act. There are currently fourteen Two Plan Model counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Los Angeles' local initiative, L.A. Care, subcontracts with several other smaller managed care plans to provide services to Medi-Cal beneficiaries.

- *Regional Model* – AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the expansion of Medi-Cal managed care into the twenty-eight rural counties not previously operating managed care plans. These counties phased in between November 2013 and December 2014. 8 counties transitioned into the COHS model, while twenty counties transitioned into a new regional model, including: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba. Beneficiaries in these counties (except San Benito and Imperial) receive services through either Anthem Blue Cross, or California Health and Wellness. Beneficiaries in San Benito County receive services through either Anthem Blue Cross, or fee-for-service Medi-Cal, while beneficiaries in Imperial County receive services through either California Health and Wellness or Molina Health Systems.

Procurement of Commercial Plans. According to DHCS, during the decades-long expansion of Medi-Cal managed care, the department has not engaged in a re-procurement process for the commercial plans that operate in the 36 counties operating under the two plan model, geographic managed care model, and the non-COHS regional model (including Imperial and San Benito counties). DHCS began its re-procurement process with a Request for Information (RFI) in fall 2020. The department expects to release a Request for Proposal (RFP) before the end of 2021, with a potential implementation date of January 2024.

According to DHCS, the re-procurement and the consequent changes in contracting relationships between the department and commercial Medi-Cal managed care plans would align with the goals of the California Advancing and Innovating in Medi-Cal (CalAIM) initiative, focusing on quality outcomes, reducing disparities, increasing access to care and care coordination, and driving delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

Staffing and Resource Request. DHCS requests 11 positions and expenditure authority of $2.7 million ($1.3 million General Fund and $1.3 million federal funds) in 2021-22, $2.5 million ($1.3 million General Fund and $1.3 million federal funds) in 2022-23 through 2024-25, and $1.6 million ($777,000 General Fund and $777,000 federal funds) annually thereafter to support the statewide Medi-Cal managed care program re-procurement effort. After release of the RFP in late 2021, DHCS expects a need for staff and resources to identify and build evaluation criteria for quality outcomes and disparities measures, to identify and review plan readiness deliverables and tools, and to transition activities for counties changing from one plan or model type to another. The specific requested staff and resources by division are as follows:

Managed Care Operations Division – Five positions and resources equivalent to two positions

- **One Staff Services Manager II** position would supervise and direct activities of analytical staff overseeing the re-procurement efforts, including the development of templates, standards, the plan termination process and post-termination reporting, as well as serving as the division subject matter expert on re-procurement, scheduling and facilitating webinar meetings with branch and management staff.
- **Two Health Program Specialist I (HPS I)** positions would lead procurement and readiness activities, create evaluation and qualification tools, evaluate and score managed care plan proposals, create readiness tools, and oversee the termination process for plans not selected to continue. These positions would continue beyond the readiness phase to support policy changes, confirm transfer of information to associate level staff, lead future implementation of service or benefit changes, assist on higher level review of deliverables and submissions, and make recommendations on approvals and process improvements.
- **Two Associate Governmental Program Analysts (AGPA)** would assist with evaluating and scoring managed care plan proposals, review readiness deliverables, and oversee termination deliverables for plans not selected to continue. These positions would continue beyond the readiness phase to support policy changes, secure transfer of information, provide technical assistance to plans to fulfill contractual obligations, and coordinate with CMS and other stakeholders.
- Four year resources equivalent to **two AGPAs** would develop evaluation criteria, review tools, oversee readiness activities, schedule and facilitate workgroup meetings, and ensure coordination among stakeholders. These positions would also be members of the workgroup to evaluate and score plan RFPs.

Managed Care Quality and Monitoring Division – Six positions and resources equivalent to five positions

Program Monitoring and Compliance Branch

- **One HPS I** position would focus on certifying and ensuring procured plans meet network certification requirements, and developing enhanced monitoring tools and compliance measures to establish adequate contract oversight.
- Four year resources equivalent to **one HPS I** would lead, oversee, and monitor compliance with network certification and delegated entity compliance with network certification.
- **One AGPA** in the Compliance Unit would oversee health plan compliance with monitoring and oversight of delegated entities, serve as lead over enhanced monitoring requirements, develop reference materials, monitoring tools, validation surveys, and review criteria to be utilized to verify compliance.
- Four year resources equivalent to **one AGPA** in the Network Adequacy Unit would monitor utilization and compliance with network adequacy standards, monitor managed care plan compliance with network and delegated entity certification requirements through data analysis, validation studies, contract review, and continual oversight.

Quality and Medical Policy Branch

- **One Health Program Specialist II** position would help develop enhanced monitoring tools and compliance measures to ensure adequate contract oversight, and would be focused on efforts aimed at strengthening the quality of preventative services offered through Medi-Cal.
- **One HPS I** would develop contract language, execute contract amendments or policy letters relating to community engagement requirements, provide technical specification design, coordination with internal and external stakeholders, second-level review and quality assurance of program staff work to support metric calculations, and production support for internal and external reports and dashboards.
- Four year resources equivalent to **one HPS I** would support the RFP process, designing and operationalizing new requirements and regulations related to department-offered quality incentives and value-based payments, and ongoing monitoring of Medi-Cal managed care plans.

Data Analytics Branch

- Four year resources equivalent to **two Research Data Specialist I** positions would provide technical assistance for new and existing managed care plans, oversee and coordinate encounter and provider data readiness testing, closeout activities of encounter and provider data submission, collaborate with clinical and technical staff to develop, implement, maintain, monitor and dispense RFP related complex coding policies and guidance, and support the data components for RFP data completeness.
- Four year resources equivalent to **one Research Data Analyst II** position would review and provide technical assistance for new and existing managed care plans, oversee and coordinate encounter and provider data system readiness and closeout activities, and prepare datasets related to ongoing monitoring, report reconciliation, and evaluation measures.

Utilization and External Relations Branch

- **One HPS I** would assist in the development and dissemination of policy changes and updates to managed care plans, engage with health plan associations and stakeholders to facilitate policy decisions.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please briefly describe the timeline of the re-procurement process.

3. Please provide some examples of the types of new requirements DHCS intends to incorporate in new managed care contracts, particularly for quality and outcomes, reducing disparities, improving access to care, and care coordination.

Issue 4: Provider Application and Verification for Enrollment (PAVE)

Budget Change Proposal – April Finance Letter. DHCS requests expenditure authority of $7.2 million ($1.8 million General Fund and $5.4 million federal funds) in 2021-22 to support enhancements to the Provider Application and Validation for Enrollment (PAVE) system.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$1,792,000	$-
0890 – Federal Trust Fund	$5,376,000	$-
Total Funding Request:	**$7,168,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The DHCS Provider Enrollment Division (PED) is responsible for the enrollment and re-enrollment of fee-for-service health care service providers into the Medi-Cal program. According to DHCS, there are approximately 182,000 Medi-Cal providers who serve the needs of Medi-Cal beneficiaries. Since September 2018, PED has utilized the Provider Application and Validation for Enrollment (PAVE) enrollment portal to automate the work of processing provider enrollment and re-enrollment applications.

PAVE is a commercial software as a solution vendor application that is used to process and track provider enrollment for most Medi-Cal providers. PAVE provides a secure, web-based portal for providers to submit their applications and maintain, up-to-date information. DHCS also uses PAVE to establish and monitor ongoing compliance with enrollment requirements by Medi-Cal providers. According to DHCS, PAVE is currently used for the following provider types: ambulatory surgical clinics, audiologists, blood banks, certified acupuncturists, certified nurse midwives, certified nurse practitioners, certified registered nurse anesthetists, chiropractors, clinical laboratories, diabetes prevention, dispensing opticians, Drug Medi-Cal clinics, transportation, hearing aid dispensers, licensed clinical social workers, licensed marriage and family therapists, licensed midwives, occupational therapists, ocularists, optometrists, orthotists, out of state hospitals, pharmacies, physical therapists, physician assistants, physicians, podiatrists, portable imaging, prosthetists, psychologists, respiratory care practitioners, speech language pathologists, and tribal health services.

DHCS intends to expand the use of PAVE to other provider types, including providers in the Family Planning Access, Care, and Treatment (Family PACT) program; Diabetes Prevention Program (DPP) providers, and dental providers. In addition, DHCS intends to make program integrity enhancements to the provider enrollment process to collect information regarding affiliations with other providers that may have been sanctioned in Medicare or other Medicaid programs.

Resource Request. DHCS requests expenditure authority of $7.2 million ($1.8 million General Fund and $5.4 million federal funds) in 2021-22 to support these enhancements to PAVE system. Specifically, these contract resources would support DHCS' work with its existing software as a solution vendor to implement change requests for the following PAVE enhancements:

- **Diabetes Prevention Program (DPP)** – Between July 1, 2021, and September 30, 2021, DHCS would enable PAVE to accommodate existing providers to submit a supplemental application to include DPP as a service. According to DHCS, there are currently 6,124 enrolled pharmacies that would be eligible to add DPP services. Newly enrolling pharmacies would also be eligible to include DPP as part of the enrollment application.
- **Program Integrity Enhancements** – Between July 1, 2021, and September 30, 2021, DHCS would enhance PAVE to facilitate new federal affiliate disclosure requirements by modifying application packages on the PAVE portal.
- **Family PACT Providers** – Between July 1, 2021, and December 31, 2021, DHCS would implement a consolidated process to allow the department's Office of Family Planning (OFP) to review and approve Family PACT provider applications after the provider is enrolled into the fee-for-service Medi-Cal program. The new process would eliminate the need for Family PACT providers to send a hard copy application to OFP for Family PACT enrollment by allowing OFP to use its own processing queues in PAVE to review and approve applications.
- **Dental Providers** – Between July 1, 2021, and June 30, 2022, DHCS would remove the paper applications and manual processes for dental provider applications.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 5: Local Educational Agencies Medi-Cal Billing Option Program Expansion

Budget Change Proposal – April Finance Letter. DHCS requests eight positions and expenditure authority of $2.2 million ($1.1 million General Fund and $1.1 million federal funds) in 2021-22 and 2022-23, and $1.2 million ($583,000 General Fund and $583,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to expand and improve the delivery of school-based health care, including contract resources to help implement expansion of the Local Educational Agencies Billing Option Program (LEA BOP).

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$1,119,000	$1,083,000
0890 – Federal Trust Fund	$1,119,000	$1,083,000
Total Funding Request:	**$2,238,000**	**$2,166,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional fiscal year resources requested – 2023-24 and ongoing: $1,166,000.

Background. DHCS administers the Local Educational Agencies Billing Option Program (LEA BOP), a school-based federal reimbursement and certified public expenditure program. LEA BOP provides reimbursement for approved Medi-Cal services to local educational agencies, such as school districts, county offices of education, charter schools, community college districts, California State University, and University of California campuses. To be eligible for reimbursement, services must be medically necessary, provided by a qualified health service practitioner to a Medi-Cal enrolled student, and provided under an individualized education plan (IEP) or individualized family service plan.

Schools are federally obligated under the Individuals with Disabilities Education Act (IDEA) to provide every child with a disability with a free and appropriate public education (FAPE) through an individualized education program (IEP). A child's IEP outlines the special education and related services necessary to enable the child to make educational progress. Many of these services, such as physical therapy, are covered under Medi-Cal's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit and eligible for federal matching funds LEAs are Medi-Cal providers. LEAs are obligated under the IDEA to find students who are in need of services and provide those services under the IDEA. The IDEA FAPE requirement obligates LEAs to pay for any services required as part of a student's IEP.

Expansion of LEA BOP. In April 2020, the federal Centers for Medicare and Medicaid Services (CMS) approved three primary changes to LEA BOP, retroactive to July 1, 2015: 1) incorporation of a new time survey methodology into the cost settlement process, 2) adding new service practitioners and new services eligible for Medi-Cal reimbursement under LEA BOP, and 3) expansion of the population covered under LEA BOP to include Medi-Cal beneficiaries outside of special education. According to DHCS, since the expansion of LEA BOP, LEAs have increasingly asked the department to provide more technical assistance, trainings, and guidance for successful administration and reimbursement under the program.

School-Based Medi-Cal Administrative Activities. In addition to reimbursement under LEA BOP, LEAs are eligible for reimbursement under the School-Based Medi-Cal Administrative Activities (SMAA) program. The SMAA program authorizes governmental entities to submit claims and receive reimbursement for activities that constitute administration of the Medi-Cal program. These activities

include referring students and families for Medi-Cal eligibility determinations, providing health care information, referring, coordinating and monitoring health care services, and coordinating services between agencies. LEAs are reimbursed in the SMAA program by determining the amount of time school staff spend performing SMAA functions using an approved time survey methodology. The time survey results are then used to calculate the percentage of school costs that can be claimed under SMAA.

SB 75 Requires Coordination Between Agencies to Improve Federal Reimbursement. SB 75 (Committee on Budget and Fiscal Review), Chapter 51, Statutes of 2019, requires DHCS and the California Department of Education (CDE) to jointly improve the coordination and access to available federal funds through the LEA BOP, the SMAA program, and medically necessary EPSDT benefits. The bill requires DHCS and CDE to create workgroups that include representatives from local educational agencies, appropriate county agencies, regional centers, and legislative staff. On or before October 1, 2021, the workgroups will provide the relevant policy committees and budget subcommittees of the Legislature and the Department of Finance with recommendations for program requirements and support services needed for the LEA BOP, the SMAA program, and medically necessary federal EPSDT benefits to guarantee ease of use and access for LEAs.

Staffing and Resource Request. DHCS requests eight positions and expenditure authority of $2.2 million ($1.1 million General Fund and $1.1 million federal funds) in 2021-22 and 2022-23, and $1.2 million ($583,000 General Fund and $583,000 federal funds) annually thereafter to expand and improve the delivery of school-based health care, including contract resources to help implement expansion of the Local Educational Agencies Billing Option Program (LEA BOP). Specifically, the positions and contract resources requested by division are as follows:

Local Government Financing Division – seven positions and $1 million contract resources for two years

- **One Staff Services Manager I** position would oversee unit staff; give final approval for research and analysis of federal and state law, regulations, legislation, issue memos, correspondence, policies analysis and state plan amendments; develop, procure, and managed the outreach campaign contract; provide guidance and oversight to the contractors to ensure all guidelines are being met; and coordinate between the contractor, stakeholders, and DHCS staff to develop a sound outreach methodology.
- **One Research Data Analyst II** position would conduct extensive research and analysis of erroneous payment corrections to guarantee claims are properly adjudicated for federal reimbursement; research, implement, and maintain the cost allocation methodology to allow LEA BOP and the SMAA program to properly report and claim costs associated with administrative activities and direct medical services; implement new procedure codes to verify compliance with federal requirements; analyze trends and utilization variances that will determine growth and evaluate the expansion of new services; examine technological alternatives to improve access to care and increase claiming for LEAs; act as program liaison with the fiscal intermediary to initiate, recommend, resolve, and implement claims processing updates or changes; conduct data runs and reports of paid claims data; enroll LEA providers as Medi-Cal providers; coordinate with the Medi-Cal payment systems and stakeholders on provider manual changes and policy updates; develop and maintain databases to capture, compile, and integrate necessary program data, spreadsheets, and other instruments to oversee the LEA BOP; develop program models to establish statewide

distribution of program information, updates, and legislative bill analyses; and develop financial or policy impacts on the program.

- **Five Associate Governmental Program Analysts** would work in cooperation with local partners and stakeholders to perform research, planning, public communication, policy formulation and analysis, and program evaluation; research and analyze federal and state laws and regulations to develop policy standards; perform ongoing program evaluations to certify statewide compliance with federal and state laws and regulations; develop contract language and procure the contract for the outreach campaign; oversee contract through assignment review, monthly invoices, and collaborate through weekly meetings and monthly status reports; train to conduct outreach activities once the contract expires; develop proposals and other documentation to recommend program changes or resolve complex policy issues; act as program liaison to state and local stakeholders; develop program models to establish statewide distribution of program information, updates, and legislative bill analyses; and develop financial or policy impacts on the program; and develop legislative or state plan amendment proposals.

- **Outreach Campaign Contract** – DHCS requests expenditure authority of $1 million ($500,000 General Fund and $500,000 federal funds) in 2021-22 and 2022-23 to support an outreach campaign contract. The contractor would be selected in consultation with CDE and the executive director of the State Board of Education, and would have experience successfully working with education entities. The contractor would develop, implement, and manage an outreach campaign for the LEA BOP, including: 1) designing an outreach methodology that meets the needs of the LEAs; 2) training and developing DHCS staff on how to maintain outreach after the contract expires; and 3) developing a five-year outreach plan with targeted goals and strategies.

Office of Legal Services – One position

- **One Attorney III** position would provide counsel support including technical assistance for matters related to the procurement and administration of LEA BOP contracts, regulation development, bill analysis, enforcement actions, sanctions, appeals, Public Record Act requests, program policy development and other legal matters. This position would also: 1) research and prepare extensive legal opinions related to complex statutory and regulatory interpretation, contract interpretation, program administration, and related disputes as required for compliance with California's Medicaid State Plan and relevant federal and state laws; 2) give ongoing legal advice for responses to community, stakeholder, LEA, county and federal inquiries; 3) draft, review, and analyze legislation, regulations, policy, procedures, and other departmental guidance; 4) provide legal research, advice, and support with the development of policies, information notices, protocols, forms, and template; and 5) provide legal assistance with drafting new regulations and review and amend the California Medicaid State Plan.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: Office of Medicare Innovation and Integration

Budget Change Proposal – April Finance Letter. DHCS requests four positions and expenditure authority of $602,000 ($452,000 General Fund and $150,000 federal funds) in 2021-22, and $566,000 ($425,000 General Fund and $141,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to establish a new Office of Medicare Innovation and Integration, which would provide focused leadership and expertise to lead innovative models for Medicare beneficiaries in California, including Medicare-only and individuals dually eligible for Medicare and Medi-Cal.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$452,000	$452,000
0890 – Federal Trust Fund	$150,000	$141,000
Total Funding Request:	**$602,000**	**$566,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and resources ongoing after 2022-23.

Background. In January 2021, the Administration published its Master Plan for Aging (MPA), which outlines five goals and twenty-three strategies to prepare the state for significant demographic changes in the years ahead, including the growth of the population of Californians 60 years of age and older to 10.8 million people by 2030. The Administration intends for the MPA to serve as a blueprint for state government, local communities, private organizations, and philanthropy to build environments that promote an age-friendly California. The five goals include: 1) Housing for All Ages and Stages; 2) Health Reimagined; 3) Inclusion and Equity, Not Isolation; 4) Caregiving That Works; and 5) Affording Aging.

The MPA identified that long-term services and supports (LTSS) may be out of reach for some middle income Medicare beneficiaries who are not eligible for Medi-Cal and do not have the resources to pay for these services out of pocket. This lack of access to LTSS places these beneficiaries at greater risk of having unmet LTSS needs, as well as greater risk of institutionalization. The second goal of the MPA, Health Reimagined, included several proposed initiatives for 2021-22, including: 1) plan and develop innovative models to increase access to LTSS for Medicare beneficiaries; and 2) plan and develop innovative models to increase access to LTSS and integrated health care for individuals dually eligible for Medicare and Medi-Cal by implementing statewide managed LTSS and dual eligible special needs plan (D-SNP) structure, in partnership with stakeholders.

Staffing and Resource Request. DHCS requests four positions and expenditure authority of $602,000 ($452,000 General Fund and $150,000 federal funds) in 2021-22, and $566,000 ($425,000 General Fund and $141,000 federal funds) annually thereafter to establish a new Office of Medicare Innovation and Integration, which would provide focused leadership and expertise to lead innovative models for Medicare beneficiaries in California, including Medicare-only and individuals dually eligible for Medicare and Medi-Cal. The new office would support the goals of the MPA within DHCS, and would provide recommendations for the Director and State Medicaid Director, and represent DHCS with CMS and other external partners. The office would explore and develop person-centered, effective and efficient strategies to deliver services, including:

- Build off lessons learned from the Coordinate Care Initiative demonstration to inform the D-SNP transition in the California Advancing and Innovating in Medi-Cal (CalAIM) initiative, and other approaches for integrated service delivery for California's dually eligible population.

- Identify best practices and build partnerships across health care, housing, and community-based providers to leverage the strengths of each sector in developing integrated, coordinated systems of care.

- Coordinate with DHCS divisions and across California Health and Human Services Agency departments that provide LTSS to dually eligible beneficiaries so that services are more coordinated and efficient.

- Develop targeted demonstration programs intended to reach special populations with complex care needs.

- Explore the feasibility of an Integrated Care at Home Demonstration in California, expanding opportunities for the provision of non-medical benefits into Medicare Advantage plans in California. Evaluate the costs and outcomes of specific non-medical benefits to guide California Medicare Advantage plans to provide the most beneficial services to Medicare beneficiaries.

- Review models to provide and improve care planning to patients and families with Alzheimer's and related dementias.

- Work with federal partners to explore broadening the approach to LTSS financing, including mechanisms that promote inclusion of LTSS benefits in Medicare and the private Medicare insurance market.

- Convene California's Medicare Advantage plans to define a strategy to integrate chronic care benefits into their plans and gain their commitment to a timeline to implement that strategy.

- Explore opportunities to enable Medigap carriers and Medicare Accountable Care Organizations to offer complementary products to cover LTSS services.

- In partnership with CMS, explore development of community-based integrated care models for Medicare beneficiaries utilizing Medicare waivers and demonstration authorities through Program of All-Inclusive Care for the Elderly (PACE) organizations, Federally Qualified Health Centers, and other provider-based risk-bearing entities.

- Explore shared savings opportunities for state-federal partnerships.

- Partner with federal, state, and local organizations to address caregiver needs.

- Partner with CMS, the California Department of Aging, and local Health Insurance Counseling and Advocacy Program (HICAP) agencies on Medicare enrollment issues.

- Develop and promote strategies to address emerging issues.

For support of the new office, DHCS is requesting the following positions:

- **One Deputy Director** would be reclassified from the existing Associate Director for Policy position to lead the new office.

- **One Staff Services Manager II** position would coordinate with external stakeholders to develop policies and initiatives, and provide leadership and subject matter expertise on dual eligible and Medicare topics within DHCS and with other state departments. This position would also coordinate with other staff on data and fiscal analysis of dual eligible and Medicare-only beneficiaries, as well as research federal and state laws and regulations, and market conditions for Medicare Advantage plans in California.

- **One Health Program Specialist I** position and **one Associate Governmental Program Analyst** would perform policy analyses and document development, issue tracking, stakeholder engagement, and coordination with internal DHCS divisions and other state departments.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

2. Would the new office publish its recommendations to DHCS leadership on achieving the goals outlined in this proposal and in the Master Plan for Aging? Does DHCS intend for this office to be a resource for DHCS leadership exclusively, or for the general public?

3. Can you provide examples of the types of projects on which the office would be expected to begin work in its first few years?

Issue 7: Behavioral Health Quality Improvement Program

Budget Change Proposal and Budget Bill Language– April Finance Letter. DHCS requests expenditure authority of $940,000 ($470,000 General Fund and $470,000 federal funds) in 2021-22, and $913,000 ($457,000 General Fund and $456,000 federal funds) in 2022-23. If approved, these resources would allow DHCS to assist county behavioral health programs to prepare for opportunities and program requirements through the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. DHCS is also requesting budget bill language authorizing distribution and administration of local assistance funds for this purpose.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$470,000	$457,000
0890 – Federal Trust Fund	$470,000	$456,000
Total Funding Request:	**$940,000**	**$913,000**
Total Requested Positions:	**0.0**	**0.0**

Background. During the fall of 2019, the Administration released a comprehensive proposal to transform the delivery system of physical, behavioral, and oral health care services in the Medi-Cal program, known as the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. Due to the COVID-19 pandemic, the Administration delayed implementation of CalAIM in the 2020-21 fiscal year. In 2021, the Governor's January budget includes funding and proposed trailer bill language to commence a comprehensive effort to transform the Medi-Cal program. CalAIM is an ambitious effort to incorporate evidence-based investments in prevention, case management, and non-traditional services into the Medi-Cal program. Many of these investments were piloted during the state's most recent 1115 Waiver, Medi-Cal 2020, and the Administration is seeking to incorporate these programs into existing Medi-Cal delivery systems on a more consistent, statewide basis. CalAIM also seeks to reform payment structures for Medi-Cal managed care plans and county behavioral health programs to streamline rate-setting and to reduce documentation and auditing workload for plans and their network providers. Other components of CalAIM include changes to populations and services that would be delivered in the fee-for-service or managed care system, continuation of certain dental services piloted in the Dental Transformation Initiative, statewide incorporation of long-term services and supports as a mandatory managed care benefit, seeking a federal waiver to allow Medi-Cal services to be provided in an Institute for Mental Disease (IMD), and testing full integration of physical, behavioral, and oral health service delivery under a single contracted entity.

Behavioral Health Payment Reform. Under CalAIM, DHCS proposes to reform behavioral health payment methodologies in a multi-step process from the current cost-based reimbursement process to a rate-based and value-based structure using intergovernmental transfers to fund the non-federal share of services. The first step in the process would transition behavioral health services from the current claims coding system, Healthcare Common Procedure Coding System (HCPCS) Level II, to HCPCS Level I. According to DHCS, this transition would allow for more granular claiming and reporting of services provided, as well as more accurate reimbursements. This transition would occur no sooner than July 1, 2022.

DHCS expects that, concurrent with the transition to HCPCS Level I, DHCS would transition to a rate-setting process for behavioral health services by peer groups of counties with similar costs of doing business. The non-federal share of rates would be provided by counties via intergovernmental transfer (IGT), rather than the current, cost-based certified public expenditure (CPE) process. DHCS would make annual updates to established rates to ensure reimbursement reflects the costs of providing services. DHCS would, at first, make payments to counties on a monthly basis, and would eventually transition to a quarterly payment schedule.

Medical Necessity Criteria Reforms. Under CalAIM, DHCS proposes to modify the existing medical necessity criteria for behavioral health services to ensure behavioral health needs are being addressed and guided to the most appropriate delivery system as well as provide appropriate reimbursement to counties. The proposed changes would separate the concept of eligibility for services from that of medical necessity, allow counties to provide services to meet a beneficiary's behavioral health needs prior to diagnosis of a covered condition, clarify that treatment in the presence of a co-occurring substance use disorder is appropriate and reimbursable when medical necessity is met, implement a standardized screening tool to facilitate accurate determinations of which delivery system (specialty mental health, Medi-Cal managed care, or Medi-Cal fee-for-service) is most appropriate for care, implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system in which they seek care, and make other revisions and technical corrections. These changes would ensure that eligibility criteria, largely being driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, would be the driving factor for determining the delivery system in which a beneficiary should receive services. DHCS proposes to make these changes effective January 1, 2022.

Behavioral Health Quality Improvement Program. The Governor's January budget also included $21.8 million General Fund for a two-year Behavioral Health Quality Improvement Program (BH-QIP) to provide incentives to county behavioral health programs to make the critical changes necessary to successfully implement CalAIM, including:

- Transition from HCPCS Level II to HCPCS Level I
- Update county information technology (IT) systems for changes to medical necessity criteria
- Incorporate managed care and other utilization data from DHCS into county IT systems
- Automate data reporting

According to DHCS, the two-year incentive program would be allocated to counties based on a formula balancing both equality and equity, as well as a framework based on meeting planning, infrastructure, reporting, and outcomes milestones.

Resource Request. DHCS requests expenditure authority of $940,000 ($470,000 General Fund and $470,000 federal funds) in 2021-22, and $913,000 ($457,000 General Fund and $456,000 federal funds) in 2022-23, to assist county behavioral health programs to prepare for opportunities and program requirements through the California Advancing and Innovating in Medi-Cal (CalAIM) initiative and the BH-QIP. These two-year resources, equivalent to three positions, would be responsible for designing the program, determining payment methodologies, managing implementation processes, distributing awards, setting measures and reporting benchmarks, monitoring progress, providing counties with technical assistance, and adapting the program based on lessons learned. Specifically, these resources would support the following position equivalents and contract resources in the following divisions:

Local Government Financing Division – Two-year resources equivalent to one position

- Two-year resources equivalent to o**ne Associate Governmental Program Analyst (AGPA)** would develop minimum county standards for progress in implementing the HCPCS transition, provide training and technical assistance to counties, analyze and monitor fiscal data and reports, review county plans for the HCPCS transition, serve as fiscal liaison to facilitate processing and flow of incentive payments to counties.

Community Services Division – Two-year resources equivalent to one position

- Two-year resources equivalent to **one Research Data Specialist II** position would review and assess county data systems and capabilities to report behavioral health performance and outcome measures, assess county capacity to support automated reporting, review and assess county capabilities to integrate managed care and behavioral health utilization data, develop guidance for plans for secure exchange of protected health information, provide technical assistance for data collection, analysis, and reporting, establish metrics for analyzing integrated managed care and behavioral health data, collaborate with other department divisions to set benchmarks and monitor and evaluate county progress.

Medi-Cal Behavioral Health Division – Two-year resources equivalent to one position

- Two-year resources equivalent to **one Health Program Specialist I** position would collaborate with other department divisions to develop and implement the incentive payment program, review and monitor county progress reports, provide technical assistance to counties, and develop quality measures that may be used for value-based incentive payments.

In addition to these position equivalents, DHCS requests expenditure authority of $500,000 ($250,000 General Fund and $250,000 federal funds) in 2021-22 and 2022-23 to support a contractor to identify county strengths, opportunities for improvement, actionable items, recommendations on implementation deficiencies, as well as training and technical assistance related to data collection and reporting, quality improvement, and administer implementation evaluations.

Budget Bill Language Request. DHCS also request budget bill language to implement the BH-QIP. Specifically, this language would add a provision to Item 4260-101-0001 that would allocate $21.8 million of local assistance funding for BH-QIP and authorize DHCS to determine the methodology and distribution of the funds to county behavioral health programs. The proposed language would also ensure federal funds are not jeopardized, allow implementation without regulatory action, and provide certain contract exemptions.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 8: Behavioral Health Continuum Infrastructure Program

Budget Change Proposal and Budget Bill Language – April Finance Letter. DHCS requests General Fund expenditure authority of $2.2 million in 2021-22, 2022-23, and 2023-24. If approved, these resources would support administration of the Behavioral Health Continuum Infrastructure Program, proposed in the Governor's January budget. DHCS is also requesting budget bill language authorizing distribution and administration of local assistance funds for this purpose.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$2,191,000	$2,155,000
Total Funding Request:	**$2,191,000**	**$2,155,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24: $2,155,000

Background. The Governor's January budget includes General Fund expenditure authority of $750 million in 2021-22 for DHCS to implement the Behavioral Health Continuum Infrastructure Program, a competitive grant program for counties for the acquisition and rehabilitation of real estate assets to expand the community behavioral health continuum. Specifically, these resources would support the addition of at least 5,000 beds, units, or rooms, including the following:

- **Treatment facilities** including crisis intervention and stabilization, crisis residential, residential treatment, day rehabilitation, day treatment intensive or partial hospitalization with housing supports
- **Housing facilities** including adult and senior care facilities, room and board with intensive outpatient services, and peer respite and shared housing. These facilities would include intensive wrap-around supports, such as enhanced care management, in-lieu-of services, and county behavioral health services.

The grant program would allow facilities to be directly operated by counties, or operated through a contract with qualified nonprofit providers. Counties would be required to provide a 25 percent match of local funds, which may include property, land, or philanthropic donations.

Resource Request. DHCS requests General Fund expenditure authority of $2.2 million in 2021-22, 2022-23, and 2023-24 to support administration of the Behavioral Health Continuum Infrastructure Program, proposed in the Governor's January budget. These resources would support the equivalent of four positions, as well as contract resources to provide training and technical assistance to counties on real estate acquisition and rehabilitation, to conduct outreach and education activities, and to develop and manage the contracting process. Specifically, DHCS requests the following position equivalents and contract resources in the following divisions:

Community Services Division – Three-year resources equivalent to three positions

- Three-year resources equivalent to **three Associate Governmental Program Analysts** would develop and implement communications and feedback mechanisms with county and tribal partners, provide technical assistance to potential applicants, monitor expenditures and local

matching funds, oversee and monitor grantees, review grantee progress reports, create a process and monitor activities to verify that federal financial participation is not jeopardized, track the progress and completion of beds, units, and service facilities.

Office of Legal Services – Three-year resources equivalent to one position

- Three-year resources equivalent to **one Attorney IV** position would perform legal research, analysis, and drafting of legal opinions and technical language for the program; respond to questions from various stakeholders; provide creative solutions to complex, novel or sensitive proposals across various legal subject matter areas; research and provide legal advice and input; and opine on matters in the three delivery systems for behavioral health services in Medi-Cal.

In addition to these position equivalents, DHCS is requesting General Fund expenditure authority of $1.5 million in 2021-22, 2022-23, and 2023-24 to support two administrative consulting contracts:

- DHCS requests General Fund expenditure authority of $1 million for three years to support an administrative consultant contract that would: 1) assist DHCS in the review of county and tribal applications; 2) provide comprehensive technical assistance and training regarding real estate and infrastructure implementation; 3) develop and execute contracts and award grant monies to tribal governments and counties; 4) provide payment to grantees for completed milestones; 5) provide oversight to ensure all land acquisition and real estate documents are secured and provided; 6) provide annual quality assurance review of awardees; and 7) develop and implement training and educational materials.

- DHCS request General Fund expenditure authority of $500,000 for three years to support a second administrative consultant contract that would: 1) perform outreach to eligible organizations, facilitate meetings with local entities, providers, and other stakeholders; 2) assist counties and tribes in preparing and completing the application; 3) assist grantees with challenges to land acquisition or other project issues; 4) subcontract with a tribal entity or subject matter experts with tribal experience to provide insight, training, and technical assistance for tribal grantees; 5) develop and deliver training and technical assistance on various real estate topics; and 6) collect and aggregate submitted quarterly reports into a comprehensive quarterly reports and a final report.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 9: Conforming and Technical Adjustments

Budget Change Proposals and Technical Adjustments – April Finance Letter. DHCS is requesting positions and expenditure authority related to its portion of two joint budget change proposals, as well as two technical adjustments. These changes are as follows:

- State Verification Hub Staff and Technical Resources – DHCS requests one position and annual expenditure authority of $998,000 ($499,000 General Fund and $499,000 federal funds) to support development and implementation of the Statewide Verification Hub, a centralized client eligibility verification system for public assistance programs. These position and resources are part of a joint April Finance Letter submitted by the Department of Social Services (see related issue in Part A of the subcommittee's agenda under Department of Social Services: *Issue 2: Spring BCP – Statewide Verification Hub Staffing Resources*)

- Annual Health Care Service Plan Health Equity and Quality Reviews – DHCS requests two positions and expenditure authority of $296,000 ($148,000 General Fund and $148,000 federal funds) in 2021-22, and $278,000 ($139,000 General Fund and $139,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to coordinate with the Department of Managed Health Care (DMHC) on the establishment and enforcement of health equity and quality standards and to perform related data analysis, particularly for County Organized Health Systems and other Medi-Cal managed care plans. These positions and resources are part of a joint April Finance Letter submitted by DMHC. (see related issue heard by the subcommittee during its May 4th hearing under DMHC: *Issue 1: Annual Health Care Service Plan Health Equity and Quality Reviews*)

- Equity Dashboard – DHCS requests reduction in expenditure authority of $117,000 ($59,000 General Fund and $58,000 federal funds) to align workload funding with the positions in the Administration's Equity Dashboard proposal. This proposal was heard during the subcommittee's February 5th hearing.

- Medi-Cal Enterprise System Modernization – DHCS requests a reduction in General Fund expenditure authority of $1.8 million and an increase in federal fund expenditure authority of $1.8 million to update the funding split in the Administration's Medi-Cal Enterprise System Modernization proposal. This proposal was heard during the subcommittee's February 19th hearing.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the DHCS-related components of the two joint April Finance Letter proposals with DSS and DMHC.

2. Please provide a brief overview of the two technical adjustments.